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ABSTRACT

Two newsletters focus on alternatives for community living and approaches to teaching social skills to children and youth with disabilities. The first issue provides information on some family support services and community-based living arrangements that are currently available for children with severe and profound handicaps or chronic illnesses. Funding through federal and state governments is described along with private medical insurance and funding through private sources. Also discussed are types of respite care (such as parent cooperatives and group respite care residences) and such community based living arrangements as teaching homes and group homes. The newsletter on social skills introduces methods for changing children's behavior and helping them acquire interpersonal skills. Basic principles for changing behavior are listed, and three methods--the behavioral method, the modeling method, and the instruction and practice method--are explained. Techniques for encouraging nondisabled children to develop relationships with disabled peers are also noted. (CL)

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NEWS DIGEST

Information from the
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APRIL 1986

Alternatives for Community Living

Parents of children with severe and profound handicaps and children with chronic illnesses are faced with extraordinary caretaking responsibilities. Such children often require intensive and skilled lifelong care (Cina & Caro, 1984; Cohen & Warren, 1985; Seltzer & Krauss, 1984; Turnbull, Brotherson, & Summers, 1985). In the past, professionals were likely to recommend that parents institutionalize children who had such intensive needs. In spite of this recommendation, and with little or no community support, parents often cared for their child at home. Now the professional attitude has changed. Parents are much less often encouraged to institutionalize their child and a variety of options have been developed both to provide parents with support in caring for their child at home and to provide a home-like atmosphere for those children who are placed outside of their natural homes. Some reasons for this change in attitude are as follows (Bradley, 1984; Cohen & Warren, 1985; Wolfensberger, 1972):

- Research showed that persons with severe and profound handicaps can grow and learn and that an environment which provides for warmth, love, caring and "a normal rhythm of the day with privacy, activities, and responsibilities (Cohen & Warren, 1985)" promotes such learning. Similarly, a home environment has been found to be advantageous for children with chronic illnesses;
- Improved methods for teaching persons with severe handicaps were developed, and professionals realized that parents could be taught the skills they would need to care for their child at home; it was also found that the parents of children who were chronically ill could learn the medical routines needed to maintain their child at home;
- Through the efforts of politically active parents, advocacy groups, handicapped persons, and others, legal changes were made which ensure the rights of persons with handicaps to participate to the fullest extent possible in everyday life (see Cohen & Warren pages 20-23 for a brief description of relevant public laws and judicial decisions); and
- In many cases, home and community care has proven to be less expensive for taxpayers than institutional care and thus public fiscal policies have been developed to support such care.

Parents who write to the National Information Center for Handicapped Children and Youth (NICHCY) often request information about what services are available to help them in providing for their child with handicaps. These include questions about services that would allow them to better care for their child at home as well as questions about placements that are available outside of the home. The purpose of this issue of *News Digest* is to provide parents and other concerned persons with information about some of the family support services and community-based living arrangements that are currently available to assist families in meeting the needs of their children who are severely and profoundly handicapped and/or chronically ill.

Family Support Services

There are several different types of family support services available through public and private agencies. Respite care, one of the most commonly provided services, will be discussed in detail in a later section. Among the other types of services provided are:

- Case management (a single person helps the family or adult who is handicapped identify needs, find available services, coordinate the delivery of services from a variety of sources, maintain records, and monitor the provided services to ensure that they are in fact meeting the identified needs);
- Habilitation services (the person with a handicap is provided training in self-care and independent living skills);
- Homemaker services (trained homemakers provide routine household care such as meal preparation, cleaning, and laundry and may also provide training in home management skills for parents or for the adult or young adult with handicaps);
- Home Health Aides (trained health care workers assist the family member with handicaps with such health-related matters as taking prescribed medication and doing therapeutic exercises, and may also assist the family with keeping health-related records);
- Nursing care (nurses provide part-time or full-time nursing care).
- Parent training (parents are

taught such skills as medical or therapeutic procedures, behavior management techniques, and methods for teaching their child independent living skills); and

- Financial aid (parents are provided money to help them pay for needed services, equipment, architectural modifications, training, or transportation that will enable them to care for their child at home).

Funding

Funding for these services has been available from state and federal government programs as well as from private sources and insurance companies.

Federal Government

At the Federal level, money has been available from Title XIX of the Social Security Act (Medicaid), from the Maternal and Child Health Block Grant (a program of grants to the states that includes what was formerly Title V Maternal and Child Health Services, Crippled Children's Services and Title XX) and the Supplemental Security Income Disabled Children's Program of the Social Security Act.

Until recently, Title XIX money was available only if the child was institutionalized. However, as a result of an appeal made directly to President Reagan by the parents of Katie Beckett, a child who is respirator-dependent, Title XIX rules have been changed (Jones, 1985). Now, federal funding can be provided for home care or community-based care if such care is less expensive than institutional care (Cohen & Warren, 1985).

Under the new rules, each state can apply for a waiver of the original Medicaid rules by submitting a plan describing the type of home care or community services it will fund with Title XIX monies. Because states have considerable flexibility developing their plans, services vary from state to state.

According to Lakin et al. (1984), all 26 states that had waivers approved by February of 1983 planned to provide case management services with Title XIX funds. In addition, more than half of the 26 states planned to provide respite care and home health aide programs. Other services were planned by a smaller number of states. These services included adult day care, homemaker services, personal care, environmental modifications, transportation, medical alert monitoring, assistive devices, occupational and physical therapy, psychological counseling, and nursing care. Summaries of the family support services each state funds with Title XIX monies are given in Lakin et al. and in McGregor (1983). A detailed summary of five states' (Florida, Kansas, Louisiana, Montana, and Oregon) applications for Title XIX funds plus a description of the federal government's review process is provided in a report by the National Association of State Mental Retardation Program Directors (1982).

Persons interested in finding out about their state's participation in the Medicaid waiver program should contact the state developmental disabilities council. While the DD Council is not responsible for implementing the Medicaid waiver, they will know about the state's participation in the program. For the address of the DD Council in your state write: NICHCY, P.O. Box 1492, Washington, DC 20013.

State Governments

In addition to federal money administered by the states, most states have their own programs to assist persons with disabilities. These programs are usually run by the departments of health, welfare, or social services, depending upon the state, and can be located through county health or welfare departments (Bilotti & Kettrick, 1984; Jones, 1985). In the past decade, state programs designed to provide support for families of persons with handicaps have grown. Only five states had family support programs in 1975, whereas 25 had such programs in July of 1985 (Report compiled by the Wisconsin Developmental Disabilities Council, 1985). By the latter date, 17 of the 25 states had enacted family support legislation; twelve states provided a cash subsidy to the family; and eight provided family support services; five states offered a combination of cash subsidies and support programs. A listing by state is shown in Table 1. A state-by-state summary including the state agency responsible for administering the program, the amount of the cash subsidy, the type of family support services provided, and the number of persons served is included in the Wisconsin Developmental Disabilities Council's (1985) report. A report compiled by the National Association of Developmental Disabilities Councils in 1984 describes family support programs in Florida, Michigan, Minnesota, and Washington. Some researchers have advocated using a voucher system as a means of providing families with the funds for purchasing respite care and other support programs (Cina & Caro, 1984). For information about a state's services for assisting persons with disabilities and their families, contact the state Developmental Disabilities Council. For the address of the DD Council in your state write: NICHCY, P.O. Box 1492, Washington, DC 20013.

Private Medical Insurance

Medical insurance companies will sometimes pay for the medical aspects of home care if they can be convinced that home care is less expensive than hospital care. In one case described by Bilotti and Kettrick (1984) a ventilator-dependent child was able to return home from the hospital when the insurance company agreed to pay the cost of instal-

ling necessary equipment in the home. Cost for this home care was $11,000 a month as opposed to $31,000 a month for hospital costs. Bilotti has found that insurance companies are more likely to respond to a personal visit from a team of professionals, including the child's physician, than they are to a letter.

Private Sources

Local chapters of national organizations such as the Association for Retarded Citizens, United Cerebral Palsy, and the Muscular Dystrophy Association can be of help to parents looking for resources that will allow them to maintain their child at home (Jones, 1985). Such agencies can provide various types of information, including information about other groups that can be of help, direct services, and financial assistance. Some agencies will provide needed equipment such as wheelchairs, emergency bed alarms, or unique items made specifically for a particular person, and some will cover the percentage of medical expenses not covered by the insurance company (i.e., if an insurance company pays 80% of the coverage, the agency would pay the remaining 20%).

Other sources of help are service clubs such as the Lions or the Kiwanis, religious groups, local companies and industries, the media, and political persons who take a special interest in a particular child or cause (Bilotti & Kettrick, 1984).

Respite Care

Respite care is one type of service available to families who want to keep their child with severe or profound handicaps or chronic illness at home, but who, in order to do so, need help in obtaining relief from the constant physical and emotional demands of caring for the child. Families may need a reliable care giver who can help them in times of emergency such as when they are coping with a divorce, illness, or death in the family. They also may need such help just to be able to go shopping, have a night out, visit friends, or go to church. Maybe they need a vacation or want to pursue an education and would be unable to do so unless they could temporarily leave their family member who is handicapped with someone they could trust (Cohen & Warren, 1985; Salisbury & Griggs, 1983; Warren & Dickman, 1981).

Many different types of programs have been developed around the country to provide such relief. Some provide sitters for children or companions for adults who come to the family home and stay while the caretaker goes out; others provide a place outside of the home where the family member with a handicap can stay on a temporary basis; still others provide both types of services.

Whether services are provided in the home or out of the home, a case manager or program coordinator is responsible for matching families who need respite care with an appropriate service provider. The coordinator is also responsible for such duties as disseminating information about the program; coordinating with other agencies; being a source of information about available services; recruiting, training and screening respite care workers; and evaluating the program to make improvements where needed (Cohen & Warren, 1985; Warren & Dickman, 1981).

Table 1
States with Family Support Programs as of July 1985

State	Legislation	Cash Subsidy	Support Services
California	X	Combination of cash subsidy and support services	
Colorado			X
Connecticut	X	X	
Florida	X	X	
Idaho	X	X	
Illinois			X
Indiana		Combination of cash subsidy and support services	
Iowa			X
Louisiana	X	X	
Maryland	X	Combination of cash subsidy and reimbursement	
Michigan	X	X	
Minnesota	X	X	
Montana		Combination of cash subsidy and support services	
Nebraska	X	Combination of cash subsidy and support services	
Nevada	X	X	
New Jersey			X
New York	X		X
North Dakota	X	X	
Ohio	X	X	
Pennsylvania	X		X
Rhode Island	X	X	
South Carolina		X	
Vermont			X
Washington	X		X
Wisconsin	X	Combination of cash subsidy and support services	

Note: This table is adapted from material provided by the Wisconsin Council on Developmental Disabilities.

Programs vary in the type of workers they hire, the amount of money they pay their workers, and the amount of training they provide. Programs may rely completely upon volunteers or may pay a token amount, minimum wage, or professional fees. One approach used successfully by some programs is to give course credit to college students studying to be human service providers in exchange for their services as respite care workers.

Most programs provide at least a minimum amount of training for their workers; however, there are some that rely entirely on the person's family to provide training. Training sessions may consist of a brief orientation session of six hours or less or may consist of as much as 60 hours of structured course work (Cohen & Warren, 1985). The content covered in training sessions usually includes an overview of handicapping conditions, a discussion of normalization and the rights of persons with handicaps, safety considerations and emergency situations, behavior management techniques, and lessons in meeting such basic needs as feeding, dressing, and toileting (Cohen & Warren, 1985). In addition to initial training, some programs provide inservice training so that workers can receive training directly related to their experiences on the job. Two other areas in which respite care programs differ is in the amount of respite care available and in the cost to parents of such care. Out-of-home programs differ in several ways. Detailed descriptions of such programs can be found in Cohen and Warren, 1985; "Models for Respite Care" in the *Exceptional Parent*, 1980; and Warren and Dickman, 1981. Brief examples of types of programs are included here as illustrations.

Parent Cooperatives

The Kalamazoo (Michigan) Parent Respite Care Co-op is one example of parents forming cooperatives to exchange caretaking services. In this case, a small group of parents obtained funding to run a respite program from the State Department of Mental Health with the cooperation of the Kalamazoo Association for Retarded Citizens and the Family and Children's Services of the Kalamazoo Area. A professional coordinator was hired to help organize the program and to provide ongoing support. Parents teach each other about the needs of their children and attend a workshop each time a new family joins. They meet once a month to discuss child care problems and other issues.

Community Home Care

There are several different forms of community home care, but in each case, families in the community provide respite care in their homes.

In Toronto, Canada, a group of parents obtained government funding to recruit host families. These host families provide as much care as they wish—up to 30 days a year, although the average amount of time is 3½ hours twice a month. The program, called Extend-a-Family, has an advisory board, a team of community volunteers, and a program coordinator. Extend-a-Family's primary goal is to provide respite care. Other important goals are providing a new family experience for the child and fostering acceptance of children with handicaps by the community. Other cities, including Syracuse, New York, have used the Toronto program as a model in developing their own programs.

In Hartford, Connecticut, the State Office of Mental Retardation seeks volunteer families to provide respite foster care. The agency conducts a careful home study before licensing families to be care givers and thereafter conducts yearly home inspections. A program coordinator meets with families who need respite care services and matches them with an appropriate foster family. Families make their own contracts and pay a fee for services, though financial aid is available if needed. The agency keeps a log of the experiences of the care givers, the parents, and the children and uses this record to monitor and improve services.

A similar program is operated in Kansas by the Kansas Children's Service League. The agency recruits, trains, assesses, licenses, and supervises respite care foster families and matches licensed care providers to families needing care. Up to 30 days of care is provided a year, with families paying on a sliding scale.

In Utah, the Early Childhood Research Program and Utah State University designed and implemented a family home respite day-care program. They developed training materials and trained state-licensed family home day-care providers to care for children with handicaps. Families of children with disabilities receive up to four hours per week of respite care, with their children staying in the homes of trained care providers. Eight other western states are now using the training materials developed in Utah and are providing similar day-care services.

Group Respite Care Residences

In these programs the child or adult with handicaps stays in a group residence specifically designed to provide respite care. One such program is run by United Cerebral Palsy of Philadelphia, Pennsylvania. This program provides respite care for up to 16 persons at one time in three apartments and one duplex furnished in a home-like manner and located in residential neighborhoods. Families can receive 24-hour care for up to 45 days a year, with a limit of 14 days per visit. Three of the 16 slots are reserved for emergency situations, and in such instances the time limit can be extended if necessary. The program is staffed with 18 full-time and three part-time trained workers. State and local funding covers the cost of the program and there is no charge to clients.

Another such program is operated by the St. Louis (Missouri) Association for Retarded Citizens. They have a 16-bed respite care building in a complex that also includes several group homes and a community center. Children and adults with handicaps can stay anywhere from a few hours to an extended period of time. While at the center, they are provided individualized, personal care; can use facilities such as the complex's swimming pool and gymnasium; and participate in structured activities. The program is staffed with nurses and trained child care aides who work on shifts. Parents pay on a sliding scale.

Community-Based Living Arrangements

Although respite care and other family support services such as those described above often enable the parents of children with handicaps to care for their children at home, sometimes more intense intervention is needed. In some instances, long-term foster care is the best alternative. A family is found who will take the child into their home for an extended period of time until the natural family is able to resume caretaking responsibilities or decides to release the child for adoption and an adoptive family is found (Taylor, 1980). In other instances, a teaching home or a group home is the best alternative.

Teaching Homes

Children with severe and profound handicaps must be taught skills that other children learn with no special training. Parents can learn these teaching techniques, but the demands of everyday life sometimes make such intensive training difficult or impossible to carry out at home. For this reason, teaching homes have been developed. Teaching homes are residences where a small group of children or adults with handicaps live with staff members who have been trained to provide daily instruction in self-care, independent living, and appropriate social behavior. Persons with handicaps may live in the home for a year or more, but the goal of the program is to teach them the skills they need to be participating members of the community. Ideally, children would return home to live with their families or would be placed with another family in the community and adults would move to a community residence.

In Oregon, two model teaching homes were established by Teaching Research, a division of the Oregon State System of Higher Education (Gage, et al., 1977). In one home, professional parents lived with four children ages 3-8 years old; in the other, three home managers took rotating shifts in staying with four children ages 8-16. Each child's training program was closely coordinated with his or her school program.

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While the children were in the program, their parents or their foster parents attended ongoing training sessions with the group home staff and were encouraged to take their children home for weekends, discuss any problems that occurred during the visit with staff members and work toward a solution. Once the children completed the program, parents and foster parents were provided continuing support through home visits and through a parent training clinic operated by Teaching Research. The Teaching Research staff also consulted with the child's classroom teachers, if such assistance was requested.

Teaching programs have also been developed in conjunction with state institutions. Providing children or adults with the skills needed to live in the community is their goal. One such program is the Camarillo Teaching Home in Camarillo, California (Glahn, Chock, & Mills, 1984); another is the Columbia State School program in Columbia, Louisiana (Ellis, Bostick, Moore, & Taylor, 1981).

Group Homes

Even with support services, not all families can care for their children with severe and profound handicaps at home. Adults with handicaps may be ready to move away from their families and establish a more independent life but not be able to live entirely on their own. A community-based group home may be the solution in each of these instances. The availability of such homes has increased remarkably since 1977 (Braddock, Hemp, & Howes, 1985; Janicki, Mayeda, & Epple, 1983). Both Federal Title XIX money for intermediate care facilities and state funding have been used to establish group homes. Braddock et al. provide a state-by-state breakdown of expenditures for establishing group homes between 1977 and 1984.

The idea behind group homes is that, unlike large institutions, they will provide a relatively normal environment for persons with severe and profound handicaps. Such an environment is provided in two types of group homes developed in response to the deinstitutionalization of Willowbrook State School in New York (Rothman & Rothman, 1984).

One of these is exemplified by two apartments in the same building in the Bronx, operated by Sister Barbara Eirich. These apartments provide a home for 12 severely and profoundly handicapped children ages 8-18. Staff members are caring persons from the neighborhood with no previous training in working with persons with handicaps. They have regular meetings with professional consultants who advise them but do not supervise them. Staff try out suggested teaching techniques but are free to modify them in response to the needs of the situation at hand. The staff members are highly involved with the children and encourage them to be as independent as possible. They join the children in participating in community life by going with one or two of them at a time to eat out, taking them to see a baseball game, accompanying them as they visit a friend, and enjoying other activities with the children.

A different type of group home is operated by Young Adult Institute.

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Their direct care staff members are college graduates with degrees in psychology, social work, or special education who have had some previous experience in working with retarded persons. These staff members have an excellent opportunity to be promoted and to become house managers or coordinators with responsibility for several group homes.

One Young Adult Institute group home described by Rothman and Rothman (1984) takes up the entire floor of an apartment building located near East Harlem in Manhattan. The floor was converted to a spacious home-like setting for ten residents with severe and profound handicaps. Daily routines and lessons are structured, and there is an intense achievement orientation, with staff working hard to help each resident attain individual goals.

Residents are encouraged to participate in such activities as going to the store with a staff member to buy ingredients for making brownies and then coming home to bake them. A major objective of the program is to encourage residents to live as independently as possible and to make decisions for themselves. To that end, they are given as many opportunities as possible to make choices; for example, they decide what they will wear, what they want to eat, and what they would like to do during free time.

These programs and a program operated by the Working Organization for Retarded Children in Flushing, New York (Searl & Wickham-Searl, 1985) illustrate how group homes can be structured to promote the growth and independence of children and adults with severe and profound handicaps and to integrate them into the daily life of the community in which they live. Unfortunately, not all group homes achieve these goals. Rothman and Rothman (1984) also describe a group home in which the staff perceives the residents as being unable to learn and treats them with little respect.

Similarly, Taylor, McCord and Searl (1981) in an article about the use of Title XIX money for community residences state that small group homes have a better chance of providing individualized, quality care for severely and profoundly handicapped persons than do large institutions, but that small is not enough. In addition to being small, such facilities should be home-like and located in residential neighborhoods; day programs should be provided outside the residential setting; and policies and procedures should promote normalization.

In the past 10 years, great strides have been made in developing high quality community-based services for children and adults with severe and profound handicaps and chronic illnesses. Unfortunately, these services are not available in all communities across the United States. In some communities, services do not exist at all and in others, although services exist, they are not based on the principles of maximum independence and integration.

As one attempt to remedy this situation, a project funded by the U.S. Department of Education is being conducted by the Human Policy Center at Syracuse University, Syracuse, New York. The project will disseminate information about existing high quality programs and will assist six states or regions currently lacking services to develop such programs of their own. As part of the project, the Center will develop a manual to be used as a guide for establishing community integration programs. One of the project's principles is that parents must be involved in the design, operation, and monitoring of services.

The need for advocate involvement and evaluation is also stressed by Lakin and Bruininks (1985) in a discussion of the challenges still remaining in providing consistent, high quality community-based services. According to Bradley et al. (1985) evaluations should be conducted by a variety of persons including volunteers (citizens, consumers, families, and advocates), professional peer monitors, private evaluators, and accreditation organizations.

Volunteers from the community can supplement professional oversight activities and are able to be sensitive and responsive to issues that professional evaluators may only be able to examine briefly (Apolloni, Meucci, & Triest, 1981). Some of the issues that should be dealt with include staff and resident relations, rapport with the neighborhood, use of community resources, contact with family members, commitment to personal growth, rights and responsibilities, personal appearance and hygiene, personal possessions, and overall ambiance of the environment (Bersani, 1984; Taylor & Bogdan, 1980).

The involvement of community volunteers can make a difference in the quality of programs available to children and adults with severe and profound handicaps and chronic illnesses. Also needed are (a) outcome-focused research, with the results being widely disseminated and used to guide program management and development and (b) comprehensive, service specific training programs for all direct-care workers (Fiorelli, 1982; Lakin & Bruininks, 1984). These, along with coordination with other community services, funding based on client needs rather than on political exigencies, and the development of committed human services agency leaders (Lakin & Bruininks, 1984) will help to ensure the availability of quality community-based programs.

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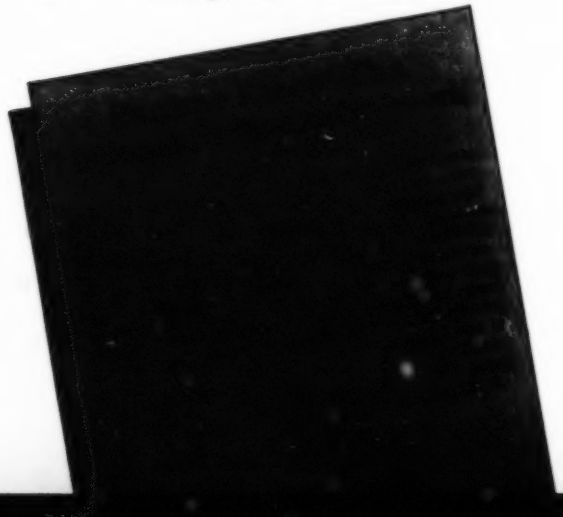

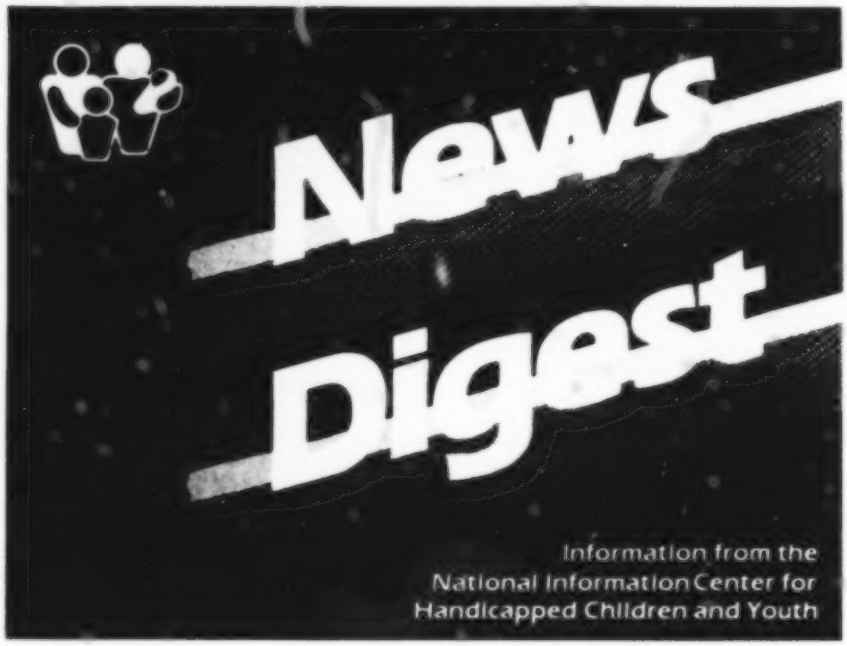

1986 NUMBER 6

SOCIAL SKILLS

Ten years after passage of Public Law 94-142 an unprecedented number of students with disabilities are nearing the age for leaving school. Special education for these young people should lead to higher education, competitive work or supported employment. However, reports indicate that between 50 and 80 percent are unemployed or underemployed, although 75-85 percent of persons with handicaps have the potential for competitive employment. The lack of appropriate social skills is one of the most frequently cited causes of this trend. Social and personal skills are critical tools for students with disabilities in making the transition from school to work. What will happen to children with disabilities when they grow up rests largely on their ability, with the help of their parents and community resources, to acquire the appropriate social skills which enable them to live their lives as independent, satisfied and productive adults.

As children grow up they learn who they are through contact with others. Their experiences begin with their own parents and then gradually expand outward to include those outside the home and family. Some children encourage positive responses from the time they are infants. Others have more difficulty in their relationships with the world. Because of an illness, a disability, or some unknown reason, they may not respond in the way expected of them. These children require special attention and encouragement in developing positive social relationships and appropriate behavior.

It should be recognized that difficulties in developing social skills are not necessarily connected to a particular level of intelligence or a certain type of family environment. A child with above average intelligence can experience severe social/emotional problems in developing social skills. In the same way, a child with no disability from a warm and supportive environment may have difficulty developing social skills while a child whose environment is unsupportive may be socially well adjusted. Children who require special attention need parents who are patient with slow or inappropriate responses, persistent in finding out what works with this particular child, and flexible in making changes needed by the child. The patience, knowledge, and skills required to help a child or young person learn to interact appropriately with others at times seems beyond any one person's ability. Indeed, getting help from an outside source may be necessary in some cases.

The National Information Center for Handicapped Children and Youth (NICHCY) regularly receives requests for information about how to teach children appropriate social skills and how to eliminate inappropriate behaviors. The frustration and despair sometimes expressed in these inquiries reflect the seriousness of the problem. It is not possible for this edition of *News Digest* to provide all the guidance and instruction parents and educators need on this complex subject. However, we hope to introduce our readers to methods that have been used to change children's behavior and help them acquire the skills they need to work with others, have friendships, achieve independence, and enjoy normal social relationships.

Identifying Obstacles to Social Interaction

The first step in helping children develop appropriate social skills is to identify the behaviors that they need to develop in order to have relationships with other children.

Because of learning difficulties some children are not able to see for themselves what behaviors are required to be accepted by others. Several studies (Brown, 1985; Donahue, 1983; Kronick, 1981; Minskoff, 1980) discuss how the learning problems of children can interfere with interactions with other children. For example, children who have visual perception problems may not be able to distinguish different facial expressions and may miss important social cues; children with auditory perception problems may mishear information and respond inappropriately; children with attention span or memory problems may have trouble knowing which information in a social situation is important and which to ignore.

Researchers have found that children with learning disabilities have a particularly difficult time carrying on conversations. These children often don't seem to understand rules of

conversation such as how to take turns, repair misunderstandings, introduce new topics, or how to select topics of mutual interest (Donahue, 1983; Kronick, 1981). They also have more trouble taking the perspective of others (Dickstein & Warren, 1980). Children with other disabilities such as mental retardation or autism may also have difficulties in distinguishing social cues and responding appropriately.

The most helpful efforts begin with observation of the child (Oden, 1980; Silverman, Zigmond, & Sansone, 1981). Then social skills training can be based on real-life situations and will be relevant to the child's immediate situation. Gaylord-Ross and Pitts-Conway (1984) describe the Frisco Interaction Scale for the Handicapped, which can be used as a guide for observing interactions and determining the type of help a child needs.

Videotapes and tape recorders can be useful aids to such observations. One innovative approach used by Gaylord-Ross, Stremel-Campbell, and Storey (1986) was to have preadolescents carry microcassette tape recorders in their shirt pockets as they worked with nondisabled young people. The recorded conversations were then used to train the students to make appropriate conversation while they worked. The same method can be used for other age groups by taping classroom activities, lunch room conversations or other social interactions.

Of course not all social skills are linked to specific situations. The observation should be based on knowledge about positive social behavior. Researchers have paid close attention to two aspects of social skills: (1) rules of conversation (beginning, maintaining, and ending conversations) and (2) responding to social cues (understanding social cues, both verbal and nonverbal, having a range of responses available for different situations, and being able to change as a result of people's reactions).

Other specific social skills include making eye contact, smiling, saying hello and goodbye, being polite, cooperating by taking turns and responding appropriately to questions, being sensitive to the feelings of others, supporting others by giving them attention or helping them, having interesting things to say, reinforcing and acknowledging others' comments, and controlling aggression and other inappropriate behavior.

Basic Principles for Changing Children's Behavior

A parent or educator who is trying to improve a child's social skills should keep in mind certain basic principles that can be used in any attempt to change a child's behavior. These principles include:

(1) Encourage children to take responsibility for their behavior. We do not control others. We can only influence others to want to change their behavior.

(2) Establish an atmosphere of mutual respect between you and the child. Children respond more positively when adults are consistent, honest, open, and supportive. (See below *Developing Effective Communication.*)

(3) Determine the behavior or events that take place before and after unwanted or undesirable behaviors. It is important to identify the things in the environment which set off or positively reinforce the child's inappropriate behavior. Sometimes a child is positively reinforced by a sense of control or the attention gained by the reaction to his or her misbehavior. It may be a useful tool for the adults to change their behavior or change schedules or events to avoid setting off or reinforcing inappropriate behavior.

(4) Explain expected behaviors and consequences to the child. Parents and teachers should be clear about the kind of behavior they expect, and the consequences that will follow if the behavior doesn't meet expectations.

(5) Establish consequences that are natural and/or logical and apply the consequences objectively (without anger). If the consequence for the child hitting a peer is to sit and think for 15 minutes, to also yell in anger or to spank the child will destroy the effect of the learning process. (Having the child sit and think for a few minutes or ignoring unwanted behavior are mild but effective forms of logical consequences.)

(6) Give positive reinforcement for appropriate behavior. It is important to make positive reinforcement a natural social reward; however, with behaviors for which it is very difficult to effect change, food may be the strongest reinforcer. The next level of reinforcers is a tangible reward such as a toy, token or other desired object. Nontangible social rewards include a compliment, a hug, time with peers, TV time, etc.

(7) Apply consequences or positive reinforcement, as appropriate, immediately following the target behaviors. The child must be able to clearly relate the consequence or reinforcement to the target behavior, if learning is to be the most effective.

(8) Select only one or two behaviors to teach or modify at one time. Don't try to solve several behavior problems at once. The child will only become confused and may not learn any of the behaviors well.

(9) Be consistent. It is important for parents and teachers to be consistent in implementing a child's program. It is also important for parents and teachers to cooperate in developing the program. Frequent communication between parents and teachers will ensure that the same behavior is being expected and that the behavior results in similar consequences at school and at home.

Along with the basic things all parents need to do to help their children develop good behavior, parents of children with disabilities can also take the following steps (Moon and Beale, 1985):

(1) Encourage their child to learn independent living skills. It takes time to teach children with disabilities skills that other children learn without instruction. Sometimes it is easier just to do the task (e.g., dressing, feeding, grooming, household chores) for the child than to be patient while he or she is learning to do it. It is important, though, both for children's self-confidence and for their relationships with others, that they learn to be as independent as possible.

(2) Ensure that from an early age their child has the same opportunity to meet people that he or she would if there was no disability. The more social experiences a child has, the more practice he/she has in using social skills. The more social contact a child has, the more opportunity there is to develop the skills necessary to interact appropriately with others.

(3) Be aware of how the child's peers are dressing and what their favorite activities and topics of conversation are. Families can then help in choosing popular clothing and learning skills needed for the child or youth to join peers in activities and conversation.

(4) Use the techniques of reinforcement, role modeling, coaching, and practice to teach the child such social skills as making eye contact, smiling, and cooperating in playing games, participating in sports, conversing or accomplishing a task.

(5) Discuss their concerns about the importance of social skills with school personnel. Parents could even provide them with information about some of the materials and programs which seem potentially effective and beneficial for the child.

Methods of Influencing Behavior Change

In addition to the above principles and ideas used to influence behavior change, psychologists and educators have identified methods that can be used to help children change their behaviors. Three examples of such methods are: the *Behavioral Method*, the *Modeling Method*, and the *Instruction and Practice Method*.

The *Behavioral Method* teaches by having children learn through positive reinforcement and negative consequences of their behavior. The *Modeling Method* stresses the role of observing and imitating others in improving social skills. The *Instruction and Practice Method* involves teaching the reasons why positive behavior is important, the rules regarding social behavior and giving students opportunities to practice appropriate behavior.

The following sections describe how these methods have been put to work to develop the social skills of children.

The Behavioral Method

Extensive knowledge exists about the behavioral techniques of using positive reinforcement and negative consequences to increase desired behavior and decrease unwanted behavior. This knowledge has been applied by researchers to improve the social skills of children with a wide range of disabilities. Researchers have found that systematic reinforcement through praise of children who are being outgoing and behaving appropriately tends to increase the desired behavior. Equally, ignoring or mildly scolding children as a logical consequence for misbehavior tends to decrease unwanted behaviors.

For children who do not respond to praise other rewards are used. For some children a system of tokens is effective. When they engage in agreed upon behavior such as saying hello to another child or sharing materials, they receive a token which they can later exchange for something desirable. Undesirable behaviors such as refusing to share result in a consequence of having tokens that have been earned taken away.

Studies have shown that for students with severe problems a favorite food is an effective basic reinforcer for desired behavior. Sometimes this is the only strategy that will work initially. This approach should be used only when other tactics will not work.

Whatever the reinforcement, it should be accompanied by words of encouragement. That way encouragement will become important to the child and other reinforcement can gradually be phased out.

Although the principles of the behavioral method are easy to understand, they may not be easy to apply. In a family situation this approach can be very difficult to implement successfully due to the necessity for consistency and appropriate timing, but it can also be very rewarding. Researchers use carefully worked out schedules of rewards, where timing and consistency are important to success. Berler, Gross, and Drabman (1982) and Cartledge and Milburn (1978) state that teachers typically do not use these methods successfully without training. Pryor (1984) has written a practical discussion of how to use behavioral techniques in everyday life. Weiner (1981) describes several behavioral approaches to increasing the social skills of learning disabled youth. Gaylord-Ross and Pitts-Conway (1984) have used these techniques successfully in working with autistic and severely retarded youth.

The behavioral approach is based on sound research and has proven to be effective; however, concern has been expressed by the Association for Persons with Severe Handicaps and other groups. They caution against the misuse of the approach, or the use of extreme behavioral means to modify the behavior of persons with severe disabilities. In a resolution passed in October, 1981, the Association supported elimination of behavior modification techniques that 1) cause physical pain; 2) actually cause or carry the potential for physical harm or death; 3) dehumanize individuals by treating them in a way that persons without handicaps would not be treated; 4) raise doubts in the minds of family, staff, and/or caregivers about the appropriateness of such techniques or their involvement in carrying them out; 5) lead to obvious repulsion or stress by non-disabled peers who cannot reconcile the behavior modification practices being used with acceptable standard practices. Readers who wish to get an overview of alternatives in modifying behavior of persons with severe disabilities should consult Meyer and Evans (1986).

The Modeling Method

Researchers have shown that social skills learning is partly based on observation and imitation of persons who are meaningful to us—family, friends, teachers, television heroes, people we admire for whatever reason. Children have also been shown to be influenced by watching videotapes of other children playing. If given the opportunity immediately after watching a scene, they are likely to imitate the behavior they have watched (Bandura, 1977). Some social skills training programs use either

live or filmed models to teach desired behavior. Whether or not modeling is effective depends on several considerations (Gresham, 1981). First, of course, the child needs to be interested enough to pay attention to the model and must be able to tell which of the model's behaviors are important. Some studies have shown that first-person narration increases children's attention to the important aspects of the model's behavior. For example, the model says, "I am talking and playing with others." Another way to increase attention to the desired behavior is to show the model being praised or otherwise reinforced for performing the behavior.

Second, the child needs to be able to identify with the model (see the model as being like him or herself in some important way) and also to admire the model enough to want to imitate his or her behavior. Third, the child needs to be able to remember the model's behavior and to be capable of imitating it.

O'Connor (1969) developed a 26-minute film that has been used successfully in increasing the contacts of withdrawn preschool children. The film shows several different children becoming increasingly involved with other children. Part of the success of this film may be the gradual increase in interaction so that children can picture themselves in the same situation. A peer modeling program designed by Lancioni (1982), which was successful in increasing social contact of children with mental retardation with nondisabled children is described later under *Combining Techniques*.

The Instruction and Practice Method

Instruction involves teaching the reasons why positive behavior is important, the rules regarding social behavior, and giving students opportunities to practice appropriate behavior. Oden and Asher (1977) helped socially isolated elementary school children improve their peer relationships with other children by arranging for each child to play games such as "Blockhead" and "Funny Bones" over a period of time with six different peers. Just before each game-playing session an adult "coach" talked with the child about what makes a game fun to play with another person. For example, the coach proposed that cooperation was important and asked the child to provide examples of both cooperating and not cooperating. Then the child and the coach discussed whether or not each of the examples would make the game fun to play for both children. The child was encouraged to try out the ideas while playing the game and afterwards the coach talked with him or her about how well the ideas had worked. Oden (1980) discusses how to adapt the method of coaching to meet the individual needs of children.

Several studies discuss techniques for instructing students in various aspects of social skills. Silverman, Zigmond, and Sansone (1981) and Weiner (1980) describe similar techniques for teaching students to be aware of how others react to their behaviors and to realize that different behaviors produce different results. In both programs, the teacher creates a true-to-life story without an ending. A small group of students propose different possible endings and discuss the likely results of each. Later the students act out the story using the different endings so that they experience the effects of changing their behavior. Sometimes the scenes are videotaped to facilitate discussion.

Weiner suggests that the students then use this new knowledge to identify and change their own behaviors that lead to negative results. Each student starts with one behavior that he or she wants to change and begins practicing the new behavior in a contrived situation where a lot of support is available. Next the new behavior is tried out in one real-life situation. Group discussion and support continue as the students gradually expand the environments in which they use their new behaviors.

Minskoff (1980) has structured an approach to teaching nonverbal communication skills to learning disabled youth which can be adapted for either elementary or high school students. It has been found that some students with learning disabilities have difficulty perceiving nonverbal cues, so the program first provides a series of tasks to help them understand the differences between cues. For example, they learn to tell the difference between such facial expressions as surprise, fear, anger, sadness, happiness, interest, and confusion. Then through the use of stories, films, and role playing they learn how to understand and use such cues in social situations. This approach can be readily adapted for use with different populations at home or in school.

Wehman and Schleien (1980), Gaylord-Ross, Stremel-Campbell, and Storey (1986) describe how to use task analysis procedures to teach persons with severe disabilities to participate successfully in such social activities as playing games or having a cup of coffee in a restaurant.

Combining Techniques

The programs described in the preceding sections use the technique described in that section as well as one or more of the other techniques. Such a combination of techniques has been found to be more effective than using only one by itself (Gresham, 1981).

Lancioni (1982) designed a program to teach social skills to three elementary school children with mental retardation who were placed in regular classrooms but did not interact with the classmates. The program used other children as tutors. After being trained, three children worked as tutors with one mentally retarded child, modeling and rewarding the desired behavior. The article describing the program is intended for researchers and is very technical, but it does show that a carefully thought out program using modeling, instruction, and reinforcement can improve the social contacts of severely withdrawn children who are mentally retarded.

Developing Effective Communication

The success of any effort to improve a child's social skills depends on the quality of the communication between the parent and the child. Over the years a number of books have been written to help parents become more effective in communicating

with their children. Works by Dreikurs (1972), Gordon (1975), and Dinkmeyer (1983), are examples of books from which parents may benefit. Though these works vary in content, there are certain themes that they have in common. The ultimate goal is to have the children accept responsibility for their own actions. Each author stresses the need for parents to communicate in an emotionally honest and positive way with their children. Gordon talks about "active listening" as a way of encouraging the child to communicate with the parents. Dinkmeyer applies the ideas on effective communications between parents and children stressing the need for children to accept responsibility for their own actions and for parents to use natural consequences in teaching their children. In addition to the works already mentioned, parents may wish to consult James, *Born to Win* (1978), Freed, *T. A. for Tots* (1977) and *T. A. for Kids* (1971), Glasser, *Reality Therapy* (1975), and Ginott, *Between Parent and Child* (1969) and *Between Parent and Teenager* (1975), for ideas and help in understanding behavior and improving communication.

Changing the Child's Peers and the Environment

So far, this paper has discussed the means for changing the behavior of children with disabilities. But there is another dimension to improving social relationships. Techniques can be used in school and play settings to encourage nondisabled children to develop relationships with children who are disabled.

Experience shows that nondisabled children from preschool age to adolescence react positively to and develop friendships with children with disabilities when given support and encouragement by adults.

Teachers who have children with disabilities and nondisabled children in their classes can take a number of steps to encourage positive social interactions:

(1) Model positive behavior by demonstrating that they like and value children with a disability and including them in classroom activities.

(2) Increase the nondisabled children's knowledge of what it is like to be disabled. Teachers can offer special lessons on disabilities, conduct group exercises or sensitization sessions, invite adults with disabilities to speak to the class, show films about disabilities and use such attitude change curricula as that developed by Barnes, Berrigan, and Biklen (1978).

(3) Use the behavioral techniques of reinforcement by praising and encouraging or otherwise reinforcing children when they are outgoing and behave appropriately. Odom and Strain (1984) caution, however, that teachers should be sensitive to the timing of their reinforcement so that they do not interrupt conversations, play or other interactions. It would also be important to avoid drawing attention to children with handicaps when they are exhibiting appropriate behavior by encouraging or reinforcing behaviors in an obvious manner.

(4) Use materials and activities that encourage children to socialize with each other as part of learning activities. Odom and Strain (1984) discuss existing knowledge about materials and activities that encourage preschool children to work and play together. They found, for example, that structured play offered more opportunities for interaction. During table time, more social contact occurred when the children glued or did puzzles than when they drew pictures or played with playdough. Another technique that has been used in increasing opportunities to socialize is to limit the amount of material used in a certain task so that children have to take turns and share. Certo and Kohl (1984) suggest that through a process of self-observation and analysis teachers can identify practices that discourage opportunities for social experiences.

Just as changing the environment in which children play has been found to encourage social contact for preschool children, methods of teaching that stress cooperation among students have been found to work with older children. The Team-Assisted Individualization and Teams-Games-Tournaments (described by Madden & Slavin, 1983, and Slavin, 1983,1984) are two cooperative learning models.

When children with disabilities are taught primarily in special classes, additional efforts are needed to encourage contact with nondisabled children. The classrooms where children with disabilities are taught need to be located near regular classrooms and their schedules should be arranged so that they eat lunch, use the playground, take academic classes whenever possible, take nonacademic classes, and share hallway lockers with their nondisabled peers (Taylor, Biklen, & Searl, 1985).

Gaylord-Ross and Pitts-Conway (1984) describe the important role of the special education teacher in promoting social integration. The teacher's own positive personal relationships with the regular staff and ability to provide the regular teachers with information, support and reinforcement for their commitment to integration is extremely important to the success of a program. They also describe a variety of programs designed to promote friendships. In one formally structured program, nondisabled young people take a work experience course where they are taught to analyze tasks and use behavioral reinforcement techniques to tutor students with severe disabilities in activities such as money management, meal preparation, leisure, and communication skills. These formal programs have been found to lead to more informal contact and friendships among the students. There are other programs that are unstructured from the start. For example, in a special friends program, a coordinator matches students according to their interests and arranges a time for them to meet, but provides no structure for their activities.

Gaylord-Ross and Pitts-Conway have also found that when nondisabled teenagers are given support from adults they are open and responsive to teenagers with severe disabilities. Odom and Strain (1984) have found the same for preschool children. They describe a program where nondisabled children are taught to engage children with disabilities in five-minute play sessions.

The sessions have been found to increase social contact among the children during the rest of the school day. Taylor and his colleagues (1985) also report that in schools across the nation where a commitment has been made to integration, nondisabled children accept and interact positively with their schoolmates who are disabled.

In conclusion, disabled and nondisabled children may need help from adults at home and in school in learning how to interact positively. The disabled child may need specific training in social skills and the nondisabled child may need encouragement and support in his or her dealings with children with disabilities. Studies show good results of such efforts, with disabled children developing positive relationships that last over time.

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Copies of most of these documents can be obtained through your local library. We have included the publisher's address in the event that the publication is not available in your area.

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Additional Resources

In addition to the books and articles listed above, the National Information Center has available a list of social skills programs that may be useful to parents, teachers and others working with children with disabilities. Readers wishing to obtain a copy of this list should write: NICHCY, Box 1492, Washington, DC 20013.

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